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ABSTRACT

The National Parent Teacher Association (PTA) believes that a major need in school health education is better understanding about what health education is, what it is for, and who should provide it. Recognizing this need, the National PTA, in 1975, initiated the Comprehensive School/Community Health Education (CS/CHE) Project. The Project has involved hundreds of parents, students, teachers, school administrators, and health care professionals in 13 states working to help communities better understand what health education means, and to rally support for improved health education in schools and communities. This manual is one outcome of the CS/CHE Project. It is intended as a guide for leaders who want better health education for their schools and communities. The ideas included in the guide were developed by PTA volunteers in the project's pilot states, and validated in eight demonstration states. The purpose of the guidebook is to present activities and processes used in those states in a way that will help others start such projects. The guidebook is organized by two series of steps that have most often led to success for others. The first series of steps is intended to help project organizers develop an overall picture of the proposed project. The second is designed to help leaders develop a successful planning process. It contains specific suggestions and ideas for the person charged with leading the planning process. In the appendix are additional materials that may prove helpful in planning efforts. These include lists of other organizations, including the State PTA Projects, where information about comprehensive school/community health education and materials can be obtained. (KC)

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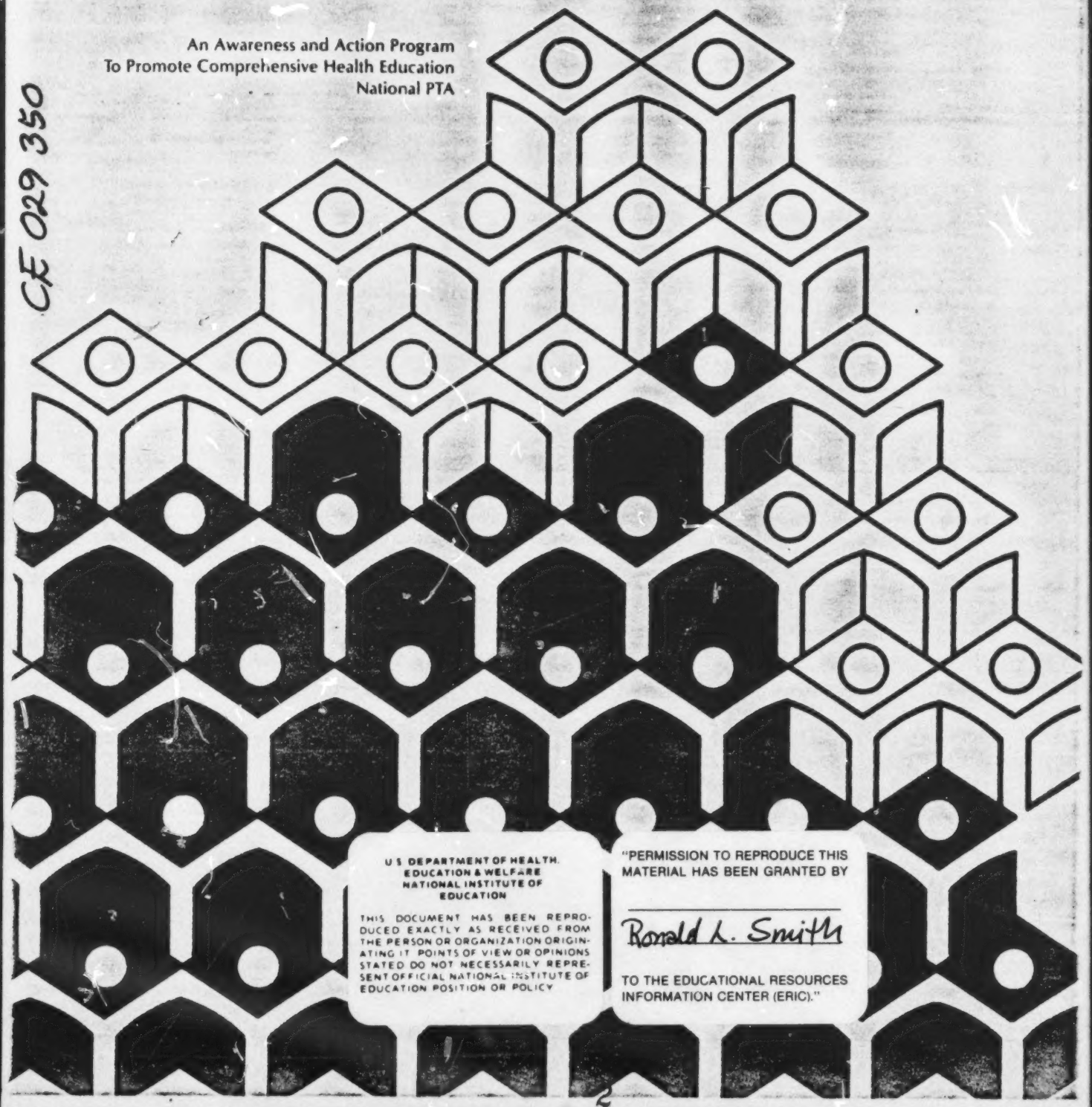
Health Education Matters

An Awareness and Action Program
To Promote Comprehensive Health Education
National PTA

CE 029 350



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The National PTA believes that a major need in school health education is better understanding about what health education is, what it is for, and who should do it. Confusion on these points hinders development of high quality health education programs.

Such lack of understanding also results in a low level commitment for health education that in turn produces insufficient time allotments, low priority among subjects, inadequate funds, as well as lack of concern about teacher qualifications and public indifference about improving this situation.

Recognizing these problems and their negative consequences for children, the National PTA, in 1975, initiated the Comprehensive School/Community Health Education (CS/CHE) Project. The Project was conducted under contract with the Bureau of Health Education, Centers for Disease Control, Department of Health and Human Services (formerly HEW), Atlanta, Georgia.

The Project signaled an important philosophical agreement between the federal government and the PTA; that while schools have primary responsibility for development and implementation of curricula, parents and community organizations have important roles as resources to the health education program.

Since 1975, the CS/CHE Project has involved hundreds of parents, students, teachers, school administrators and health care professionals in 13 states. They have all worked toward two goals:

1. to help communities better understand what health education means
2. to rally support for improved health education in schools and communities.

This manual is one outcome of the CS/CHE Project. It is intended as a guide for leaders who want better health education for their schools and communities. The ideas included in the guide were developed by PTA volunteers in the Project's pilot states, and later validated in eight demonstration states.

The variety of successful activities undertaken in these Projects supports the notion that cooperative voluntary efforts between community organizations, government agencies, citizens and health education professionals is not only possible but necessary for effective planning for health education.

This leaders' action guide is intended as an aid to planning. It shows what steps to take to develop awareness and support for health education, and it also suggests how these steps might be taken.

Finally, I would like to extend a word of appreciation to all who made the CS/CHE Project a success, and especially to the many PTA volunteers for their dedication and creativity.

Virginia V. Sparling

Virginia V. Sparling, President
National PTA
1979-81

A 1973 National PTA resolution expressed the position that schools have the primary responsibility for developing and implementing K-12 health education curricula and learning activities. (See Appendix A) As a result of that resolution, the PTA proposed a program to make the public aware of the need for a sequential, coordinated and systematic approach to health education with active community involvement under parent leadership.

In response to the proposal, the Bureau of Health Education awarded a contract to the National PTA in May, 1975, to initiate the Comprehensive School/Community Health Education Project (CS/CHEP). State PTAs submitted proposals to the National PTA project committee and staff competing for funds to conduct statewide or local activities promoting health education.

During the first three years of the CS/CHE Project, PTA leaders in six states—Arkansas, California, Colorado, Georgia, Indiana and Pennsylvania—acted as catalysts, bringing together PTA members, state and local health education professionals and organizations, professional educators and concerned community members. Drawing upon their expertise in the field, these participants developed and implemented public awareness strategies promoting comprehensive health education. Finally, the results of their efforts were showcased in a national meeting in 1978 where PTA/PTSA leaders and others examined the pilot Projects.

Since that meeting, nine additional states were selected, also on a competitive basis. Arkansas, California, Idaho, Florida, New Hampshire, New Mexico, New York, North Carolina and Ohio have drawn from those experiences and developed new plans to support and improve health education. Furthermore, these state PTAs also identified specific areas of critical concern in their states and used them as the focus of their health education Projects. Those concerns included childhood immunization, sex education, prevention of sexually transmitted diseases, smoking prevention or cessation, nutrition and alcohol education.

The increases in health education awareness and action have demonstrated the effectiveness of their planning and action. Those actions included local workshops, regional conferences, community health education councils and state-wide task forces that assisted in leadership training, program development and community awareness campaigns. During the fifth and final year of the CS/CHEP, meetings were held in five areas of the country to showcase the methods and materials used by the pilot and demonstration State Projects.

Another activity of the CS/CHE Project focused on students. Student health education forums were held in four regions of the country in 1980. These forums were planned and conducted by students to identify health education issues of concern to them. The students reported their recommendations to the National PTA Board and the Bureau of Health Education. These reports will then be disseminated to national and state organizations, encouraging them to involve young people in their program and policy decisions.

health

The CS/CHE State Projects demonstrated that priorities for health education vary from community to community. Regardless of such differences, however, all programs had certain activities or processes in common. The purpose of this guidebook is to present those common activities and processes in a way that will help you start your own project. This action guide cannot tell you what will work in your community, but it can help you determine what might work.

The guidebook is organized into two series of steps that have most often led to success for others. The first series of steps is intended to help you develop an overall picture of your proposed project. The second is designed to help you develop a successful planning process and it contains specific suggestions and ideas for the person charged with leading the planning process. Key concepts are highlighted by .

In the appendix, you will find additional materials that may help you in your own planning efforts. These include lists of other organizations, including the State PTA Projects, where information about comprehensive school/community health education and materials can be obtained.

The planning framework offered in the guide is only a suggestion to get you started. Be imaginative and adapt the outline to your special needs. Modify the steps to match your style. Remember, the process presented here was developed by volunteers working as time permitted, without paid staff. Use your ingenuity.

Contents

Page		
	7	**I. The Matter of Health Education: An Overview**
	7	A. A Concept of Health Education
	7	B. A Rationale for Comprehensive School/Community Health Education
	8	C. Support for Comprehensive School/Community Health Education
	10	**II. A Planning Process for Improving Health Education**
	10	A. Organize the Steering Committee
	11	B. Assess the Current Status of Health Education
	14	C. Generate Project Objectives and Ideas
	18	D. Develop and Choose Project Ideas
	19	E. Implement Project Activities
	23	F. Measure Project Progress and Outcomes

Strategy notes for each of these steps are separated from the text by

	27	**III. Appendix**
	28	A. Comprehensive School Health Education Program Resolution of the National PTA
	29	B. The School Health Program
	30	C. State School Health Education Programs
	32	D. School Health Educator Certification
	33	E. Assessment Tools Used by State PTA Projects
	34	F. Organizational Support Structures
	35	G. Activities Chart
	36	H. Resources for School Health Information
	37	I. State PTA Project Materials
	39	**IV. Key Terms**

I. The Matter of Health Education: An Overview

Everyone has some idea of what health education is and of what is needed to improve it. There are wide differences of opinion, however, regarding approaches to improving school health education. Unless resolved at the outset, these differences in perspective and opinion by well-intended individuals could lead to subsequent differences in interpretation and eventual undermining of the project. Proper planning is one way of ensuring understanding and coordination in undertaking a project, but even before planning begins, it is important that everyone involved be on the same "wave length," and that they all share a common understanding of concepts, rationale and intent related to the project.

A. A Concept of Health Education

There are many concepts of health education. Some focus on disease and its early detection and treatment. Others focus upon disease prevention through particular behaviors. Still others address maintenance and promotion of health among well people. Some concepts are subject-specific (sex, drugs, smoking). Others focus on special groups (patients, minorities, the elderly) and still others upon geographic areas (rural, urban, etc.).

The concept adopted by the CS/CHE Project incorporated elements of all of these but remained unique in that it derived its goals and objectives from children's needs for orderly growth and development, in all dimensions—physical, mental, social and emotional. (See Appendix A)

Health is more than the absence of disease. Educating people for health means more than teaching them how not to get sick. It means teaching them how to become knowledgeable, independent, positively functioning human beings.

Health education is a planned effort to help people gain sufficient control over themselves and their environments to protect and enhance their growth and development. The aim is to enable an individual to:

1. become a self confident, intelligent, physically fit, emotionally stable and socially responsible person.
2. solve problems by reasoning critically, evaluating alternatives, and choosing and acting on solutions.
3. cope with life by facing and adapting to new ideas, experiences and changes.
4. initiate change when needed to protect, promote and maintain personal health, including appropriate use of information, service, products and facilities.

B. A Rationale for Comprehensive School/Community Health Education

Since the turn of the century, advances in medicine and public health have brought under control most of the threats to health from communicable diseases. It is now apparent that further major improvements in the nation's health will more likely come from personal decisions and actions than from biomedical breakthroughs. School health education can aid in that process.

Health education in the school setting should provide students with a foundation of accurate information upon which to build sound health habits, values and decisions. By addressing health issues and problems and the causative behavior of future problems at each grade level, students are encouraged to develop lifestyles that foster good health. This is one aspect of comprehensive health education—a sequential K-12 program geared to the changing levels of student skills and understanding.

The school health education curriculum shares these and other goals with the overall school curriculum. The primary goal of schooling is to help students become knowledgeable, critical, self-directed learners. The health curriculum applies knowledge, along with critical reasoning abilities and learning skills, to understanding

normal growth and development and maintenance of well being. It is assumed that people thus equipped are more likely to live healthful lives than those who are not. There are no guarantees.

A balanced program of school health education addresses growth and development, mental health, parenting skills and family relationships along with fitness, nutrition, care of the body and protection of the environment. In addition, health education examines the relationship of lifestyles to such health problems as hypertension, communicable diseases, mental illness, obesity and the effects of drinking, drug use and smoking. Health education topics are not presented in a vacuum but are related to students' decisions, concerns, interests and experiences.

Health instruction is one component of the overall school health program. Another component is health services which include health assessment, screening, counseling and referral, and emergency procedures. A third component is the school environment which, if it is health enhancing, includes a safe physical plant, supportive emotional climate and adequate food services. A comprehensive school health education program, while based in the curriculum, utilizes learning opportunities in all components of the school health program. (See Appendix B)

In summary, then, the rationale for comprehensive health education is based on: a sequential K-12 program that grows with the student; a curriculum that integrates knowledge, reasoning, attitudes and behavior to the benefit of individual growth and development; and a school health program that encompasses health instruction, health services and a healthy school environment.

C. Support for Comprehensive School/Community Health Education

Accepting the concept for health education and understanding the rationale for comprehensive health education are crucial first steps, but by themselves do not establish a workable comprehensive school health education program. Certain conditions lend support.

These conditions are parent and family involvement and the support of community agencies which together form a system of support that can improve any school health education program. This support system

- assures continuity
- strengthens the role and responsibility of the school for its school health program
- advises school boards
- coordinates the myriad resources
- and participates in the evaluation process.

Working Together

For the past several years, as part of the Comprehensive School/Community Health Education Project, PTA members and other concerned individuals in many communities have helped formulate new approaches to school health education programs. Volunteers developed a variety of methods to increase awareness and understanding of health education needs and resources and to develop support for more effective and mutually reinforcing health education programs. While the approaches differed significantly, their success has been facilitated by one common factor: a broad community support system. The support systems that evolved were comprised of members of every segment of the community—parents, students, teachers, educational administrators, service organizations and health professionals. Their combined contributions of time, energy, expertise and enthusiasm were the means of accomplishing important changes in health programs.

Role of Parents

Significantly, much of the success can be attributed to the role of parents in all phases of project planning and implementation. Parents are the first and continuing health educators of their children. Parents and families are the natural role models for health behavior; fundamental attitudes and values, too, come from parents. Involvement in the decision making process helps parents to identify and clarify these existing skills and increase their contributions as partners in the education of all children, not just their own. Their contributions are equally important as those

made by education and health specialists. Tapping all available resources early in the planning stages may be a key factor in the success of your program.

Schools have primary responsibility for planning, implementing and evaluating the health curriculum. Parent-led community support systems can make that task more efficient, more effective and, in some cases, can make the difference between having and not having school health instruction.

Role of Official State Agencies

Above and beyond the coordination of activities within individual community support systems, there is also another level of coordination that enhances the probability for the development of comprehensive health education programs. Since the legal and financial responsibility and resources for education rests with the state government, your activities should take into account the goals and direction of the official state agency for education or public instruction and the guidelines and other resources for health education which may be available from this department.

From state to state, there is great variance in resources and priorities for health education among the official education and health agencies. This matter will be dealt with in the next section, but, when possible, your attempts to develop awareness programs and support systems should address the goals and directives of those agencies.

On a related note, your activities also should reflect coordination within the structure of your own organization. The scarcity of financial and human resources to undertake new programs requires coordination, assistance and the sharing of resources and experiences. Whenever feasible, this cooperation should be a planned aspect of the overall effort.

Coordination with both government and voluntary interests in health education assures more appropriate use of resources and unnecessary duplication of efforts. This itself is a valuable support service to the school administrator who must deal with many health interest groups, each with program resources targeting the school age population.

II. A Planning Process for Improving Health Education

Planning is a sequence of steps to get you from an idea for some overall goal or purpose to an end point where that goal is realized. In this case, the goals are development of awareness and community support for comprehensive health education. The CS/CHE Projects have shown that as conditions, priorities and needs vary from one community to another, so do the solutions and the ways by which those solutions are found. Nonetheless, there are some elements in the planning process that are common to all the State PTA Projects.

This section of the manual is designed to help you organize your project. A basic framework is presented to guide you through the planning steps. Resource materials developed by the State Projects, sources of information and other aids are included as appendix items.

A. Organize the Steering Committee

In the first section of this manual, certain conditions were cited as being necessary to support comprehensive school/community health education. For any successful health education program, parent and family involvement and the support of community agencies, together, are needed to assure continuity, strengthen the school's role and responsibility for its school health program, advise school boards, coordinate resources and participate in the evaluation process. The integration of all these activities into a community support system is the goal of your project, and to oversee this integration, your project should have a coordinating or steering committee.

As the person responsible for overseeing the development of a health education awareness and support system, your first concern is to put this coordinating or steering committee together, if one does not exist. Your first steps, then, are to:

1. find out how parents are involved in health education and their level of knowledge and interest in health programs
2. discover whether a group already exists that can function as a steering committee, and whether parents are members of that group
3. if such a group does not exist that is appropriate for your needs, establish your own health education project coordinating or steering committee.

The makeup of the committee will vary depending on the level (state, regional or local) to which your project is directed, and the availability of interested, capable and knowledgeable persons in your area. In general, however, the steering committee for the State Projects had broadly based representation by parents, PTA members, school teachers and administrators, persons from state or local health and education departments or agencies, and voluntary community organizations with interests in health and education. Student representation might be considered.

Be careful not to make the committee too large to function adequately. One way of limiting the size while expanding the scope of the steering committee is to form *ad hoc* or liaison arrangements with individuals or organizations who would offer their services or expertise upon invitation at appropriate periods during the committee's planning efforts.

Your Initial Steering Committee Meeting

Once the steering committee is organized, your primary responsibility will be to guide this working party through the planning process toward attainment of an awareness and community support system. The next sections of this manual describe the steps to be taken. As the person who will guide the steering committee through this process, there are a number of preliminary actions which you can take to reinforce your leadership and facilitator role.

First, read through the entire manual prior to your first meeting and become acquainted with the planning process. Second, become familiar with the background and current responsibilities of the persons chosen to be members of the steering committee. Third, prepare an agenda that:

a. allows ample time for getting acquainted
b. covers definitions of terms and concepts so that everyone is at least using the same meanings for words during discussion (The key terms at the end of the appendix may be useful at this point.)
c. moves the group toward agreement on the overall project goal, and on what is expected of the committee
d. gives each member an opportunity to share his or her views or perspective and any supportive data available.

B. Assess the Current Status of Health Education

A primary task that the steering committee faces is that of assessing the current status of health education within the community and/or state. This activity may or may not begin at the first meeting of the steering committee, and it more than likely will take longer than one meeting to accomplish. The more thorough you are in assessment, the better defined your project objectives, the more specific your project activities, the greater your chance of having an effective project.

Assessment of health education, although defined here as a specific task, may not be all that distinct or separate an activity, depending on how formally or informally it is conducted. Once your steering committee members understand the concept of comprehensive health education and are given a chance to present their views on the matter, for all practical purposes assessment may have begun, in an informal sense. In future meetings, you or your committee may decide to perform a more formal assessment.

To help facilitate the initial discussion on the current status of comprehensive health education in your area, the following general questions were useful to the Project committees and will give you some insight into the types of topics that need to be addressed. Do not limit yourself to only these questions; they simply provide the framework which can be expanded by your participants. Read through the questions before the meeting; you may think of others that might add more depth or clarification to the discussion.

- Is the political climate receptive to improvements in comprehensive health education?
- Have there been previous efforts to improve comprehensive health education? Did they succeed or fail? Why?
- What is the general community's attitude towards comprehensive health education?
- Where in any existing framework will this steering committee fit?
- How will this project relate to the goals and programs of your state or local organization?
- What is the potential relationship of this project to any ongoing or planned state or regional comprehensive health education effort of the state department of education, public health and/or mental health agency, state medical society or auxiliary, cooperative extension program, health planning group, etc.?

During the discussion of these questions, encourage the committee members to share their expert knowledge and advice with the whole group. The group should take particular note of those areas that need improvement or additional research, since these ideas will form the basis of the planning phase. A committee member should record the comments and the conclusions of each meeting.

Formal Status Analysis

Initial discussions of the status of comprehensive health education more than likely will result in more questions than there are answers. This was a common experience of the State Projects. But if the number of unanswered questions or spinoff discussions become substantial, you may suggest to the committee that a more formal approach be taken by grouping the questions or discussions into more manageable

clusters. Here is a suggested set of categories and associated tasks to consider. You may think of others.

1. **Legislative Guidelines:** identify and evaluate present legislative and policy guidelines; suggest changes in identified areas of need; elicit support of those who can authorize these changes.
2. **Educational Organization:** identify the system responsible for planning, implementing and evaluating health education programs.
3. **Communication Network:** examine the effectiveness of communication among those with interests in and responsibilities for health education.
4. **Health Education Resources:** identify human, physical and financial resources available from all sectors of the community to support comprehensive health education.

At this point, you may want to consider whether additional resource people should join the steering committee on an *ad hoc* basis throughout the assessment phase.

In setting up a more formal assessment of health education status, you may want to obtain comparative data to aid in assessment.

Examples of useful kinds of data are contained in:

- Appendix B: The American Medical Association's *Physician's Guide to School Health Curriculum Process* outlines the features of a comprehensive school health program.
- Appendix C: the American School Health Association (ASHA) study, *School Health in America*, provides a table showing each state's requirements in health subjects at elementary and secondary school levels.
- Appendix D: The ASHA study, *School Health in America*, lists the state requirements or conditions for school health educator certification.

These sources of information should provide your steering committee with a sense of the kinds of structures (laws, regulations, guidelines and organizational entities) that enable development, improvement and/or expansion of a comprehensive health education program. (These appendix pages may be reproduced for your committee; but be sure to include "permission to reprint" statement.)

The following questions, grouped according to the four previous categories, are suggested as a way of pinpointing specific issues that underlie the current status of health education. The questions are not meant to be answered in yes or no terms, but rather will facilitate discussion of the "hows" and "whys" of health education.

As you discuss the questions, pay particular attention to the factors that affect decisions (or lack of decisions) on matters that favorably or unfavorably influence the status of health education. Record the committee's comments, for they will be used later to develop project ideas.

Legislative Guidelines

1. What are the state (local) health education guidelines for content, performance or program development?
2. Is health education legislation mandated or permissive? What are the implications of this status?
3. What are the requirements for teacher preparation and certification in health education? What is the status of school nurses regarding teaching responsibilities?
4. What variances occur between state and local policies?

Educational Organization

1. What does the data show from statewide (local) studies regarding student health knowledge, attitudes and behavior?
2. Is there an advisory group for health education to the state (local) school board or state department of education? What is its status? What is its representation? Are parents and students members of the group?
3. What groups are involved in the planning, implementing and evaluating of health curriculums at the state (local) level? What procedures are followed?
4. What kind of assistance does the state provide to schools and communities regarding the evaluation of health education materials and/or methods?

5. Does the curriculum address the physical, social, mental and emotional dimensions of health?
6. How is the health instruction related to other academic subjects?
7. How are in-services planned and financed for periodic updating of curriculum organization and content changes?
8. How are the health curriculum and services coordinated, evaluated and updated?

Communication Network

1. In the state department of education, are there lines of communication and cooperation with other related departments?
2. Within the state (school district) what internal lines of communication and cooperation are there among school health personnel? Examples are newsletters, professional organizations.
3. What are the lines of communication and cooperation among concerned health organizations?
4. Are there lines of communication and cooperation between the state (local) school personnel and concerned health organizations?
5. To what extent do parents communicate and cooperate with the school health program personnel?
6. What means of disseminating information to the public at large are available?
7. In what manner is the PTA involved in facilitating communication and cooperation between the interested groups?
8. What means of disseminating information are available between organizations at the state level and between the state and local levels?

Health Education Resources

1. What organizations and departments are actively involved in promoting school-centered health education programs? How are they facilitating these efforts?
2. Who at the state (local) level is able to offer consultation of qualified health education personnel to curriculum committees, administrators, or parent and community planning groups?
3. What kinds of involvement do parents, students, educators and community members have in health education decisions and policy at the state (local) level?
4. What school and community resource people assist the teachers? How are parents involved?
5. What health education materials are available? At what costs? Are they adaptable to the school health education curriculum?
6. Do schools and communities know where to find up-to-date, educationally sound health education books and audio-visual materials available for use in schools and communities? At what costs? Is there a mechanism for parent and student review?
7. What (local) sources of funds are currently available for health education programs? How are these funds being used?
8. Are there indications of overuse, underuse or inappropriate use of school or community health services that may be a result of inadequate health education?
9. Does the state education library have up-to-date, educationally sound health education books and audio-visual materials available for use in schools and communities? Are these materials available from other sources?

If your meeting is organized at the state level, then your participants need only address the questions at that level. These questions are designed to identify current policies, resources and limitations originating with state personnel and organizations. As the participants analyze the questions and try to agree on some answers, be alert for a weakness in any particular area. It may be that a series of questions is difficult to answer because a representative from a certain field is missing from your meeting.

If your meeting is organized at the local level, you should cover *both* levels with group members. If discussions at the state level have been held already, try to obtain a copy of any report or conclusion of these discussions. If no report is available, invite a representative from the state group to pass on the information to your committee members and discuss the implications for your local level.

Assessment Tools

In carrying out their assessment of health education, some of the committee members might express an interest in examining the assessment tools used in the PTA State Projects, or decide to design a checklist of items deemed relevant to the assessment process. Sources for these tools are listed in Appendix E.

Your state department of education may have guidelines for reviewing the scope and quality of school health programs. Arkansas, Indiana, California, Idaho and Ohio are among those PTA Project States who used such materials to inform and to encourage the school boards and administrators about the need to improve health education programs. The Project steering committees did not necessarily collect data with these instruments but used them to educate themselves and their constituents about the components of health education programs.

The Ohio PTA used "A Self-Appraisal Checklist for School Health Programs" in their project. This guide recommends that an evaluation team, with broad representation, review and discuss the guide prior to its use. Then the team formulates a plan of action to help insure that techniques and resources are available to complete the study appropriately, and proceeds to evaluate the school health program.

In addition to specific assessment tools and checklists, there are other resources that may assist you in determining the status of health education. These resources include: state curricula for comprehensive health education, which are developed and distributed by the state education and/or health department, and the local school's written guides, which deal primarily with policies.

Materials often are produced and distributed by an agency or organization with a special health or disease prevention interest. These materials are not assessment tools or comprehensive health curriculum but more appropriately serve as teaching aids.

There are other sources of information that might be used. School districts, colleges and universities often do studies of statewide or local health and health education needs. The University of Georgia conducted a statewide study of college freshman students' health knowledge. That was the basis of the status analysis of the Georgia PTA Project. Health systems agencies also generate community "needs assessments," which are usually in terms of health services required, rather than health education programs needed. And finally, there are so-called health knowledge inventories and health attitude studies carried out by both private and public agencies, which all too often have the intent of calling attention to a particular problem area or categorical health issue rather than to raise the level of objective knowledge.

Your steering committee may find any or all of the above helpful in its deliberations, but it should keep in mind the limitations that these materials may impose.

C. Generate Project Objectives and Ideas

The process of developing a project can be seen as one of alternately expanding and narrowing the group's thinking. The initial assessment phase of the committee is a period of expansion as information is sought and collected about the status of health education.

In identifying the forces that both help and hinder the cause of health education, the group narrows its focus by selecting relevant information and isolating specific factors affecting the course of health education. Now the group is ready for another expansion period, one in which program ideas are developed.

The State Project steering committees discovered there was no single sure-fire way to develop or generate program ideas or objectives. There are many ways. Five of them are described in this section, and examples of how the State Projects incorporated these procedures are presented. You may decide to combine some of these methods or you may find others that are useful.

1. Sometimes ideas come out as a natural or logical response to thinking about the group's purposes or goals.

In Arkansas, for example, the state PTA decided it would act as a catalyst to coordinate and implement school/community health education programs. Its purpose defined, the PTA set about to organize a state comprehensive school/community health education council and local councils in 20 school districts. Indiana also sensed

the need to coordinate the independent activities throughout the state, and chose to develop teams in each of the state's 28 PTA districts who would serve as a network of leaders to assure active representation by a local PTA member on major health councils and regional health planning units.

There are certain questions which the group can ask itself in formulating objectives that are limited to the group's statement of purpose, such as:

- Is the statement of purpose an event or situation that will take place in the future?
- Is the statement made in terms of what others will do, *or* in terms of what the steering committee will do?
- Is the statement clear enough so that you will be able to tell when you have reached the goal?
- Do the objectives fall within the broad purpose which brought the group together in the first place?
- Is the combined list short enough to be manageable? Keep in mind that the objectives of specific activities can be spelled out later.
- Do the goals generate enthusiasm? Do they clarify the reason that the group has joined together?

Arkansas and New York PTAs used a modified nominal group process for needs assessment. This process is designed to allow total participation among group members in generating ideas concerning a topic. Here's how it works:

1. Each participant is given a form with the question, for example, "In your opinion, what are the most important current health needs of the school age child in this school district that health education can help solve?"
2. Each participant is asked to work silently and independently and to write at least four short sentences or phrases in response to the question.
3. After about 10 to 15 minutes, the leader lists all items from each participant on a flip chart, ignoring duplication and without discussion of the items.
4. The leader allows 10 to 15 minutes for the group to discuss items on the flip chart for clarification only.
5. The leader then asks each participant to select from the flip chart those items he or she considers most important. Then, using one 3x5 card for each item, each person writes his choices on a set of cards. The participants then rank their 3x5 cards in order of importance, assigning #1 to the lowest priority item. The leader collects the cards and tabulates the vote on the flip chart before the entire group.
6. A 10 minute discussion of the ranked priorities follows.
7. The leader then asks participants to re-rank, in order of importance, those items on the flip chart that he or she feels most important. During this re-ranking activity each participant is asked to assign a priority number between 0-10 to each item. (0 is lowest, 10 is highest priority.)
8. These re-ranked numerical priorities are then listed on the flip chart. The needs with highest numerical ranking are given top priority.

(This modified nominal group process is adapted from "The Nominal Group Process of the Program Planning Model Leader Format" by Andre L. Delbecq, Ph.D. and Andrew N. Van de Ven, Ph.D., Graduate School of Business, University of Wisconsin, and reproduced by permission of authors and the *Journal of Applied Behavioral Science.)*

2. Sometimes ideas are derived from brainstorming sessions in which participants are invited to state any ideas they have, whether broad or narrow in scope. This exercise can be limited to the steering committee if the group feels its makeup is diverse enough to generate a variety of ideas; or the committee could ask additional leaders or thinkers within the community to participate in the brainstorming activity.

Florida, Georgia and North Carolina were among the Project states that went through this kind of process as they examined various categorical health issues and

responded with suggestions of a wide variety of potential objectives for consideration.

Brainstorming is one method that can help a group of people get involved together in the process of generating creative ideas. A facilitator writes the topic or question to be brainstormed at the top of a large sheet of paper, then asks the group to call out their ideas in short phrases that can be written down quickly. To set a creative, high-energy tone, the following guidelines should be stated to the group from the onset:

- No judgments. No idea or suggestion, no matter how wild, is to be shot down or edited. (There will be time to evaluate the ideas later.)
- Anything goes. Offbeat, unusual, humorous and bizarre ideas are encouraged.
- Go for quantity, not in-depth discussion. The more ideas, the better the chance of coming up with a winner.
- Building on other people's ideas is fine.

Some questions to get the committee started on the brainstorming process are:

- What *should* be done?
- Given unlimited resources and full support, what could the committee do over the next 5 years?
- What are some program ideas that might help us carry out our purposes?
- What are other groups doing that we might want to try?

The facilitator of the brainstorm can help to keep things moving, if necessary, by 1) setting a time limit—commonly 3 to 10 minutes (depending on topic and size of group)—so that people will know they can't afford to sit on an idea; 2) giving a few examples to start things off (a "hailstorm"); 3) praising, coaxing (gently); 4) asking for different sorts of examples if the group starts to develop a "one track mind."

3. Under certain conditions a valid objective could be the improvement of an idea already initiated.

In California, for example, the state PTA found that in the high schools where a health education course was offered as an elective, over half of the students did not choose to take that course. Futhermore, only 48 percent of the school districts had written goals and objectives for health education in spite of the state mandate. In response, the PTA decided to direct its program toward educating school boards in the community to support that mandate, and to encourage the use of the California Framework for Health Instruction to expand comprehensive health education.

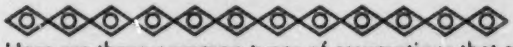
The State Planning Committee for Health Education in Ohio (SPCHEO), an advisory body of health and education professionals, had no provision for including PTA members in its activities. So the Ohio PTA set as one of its objectives the involvement of SPCHEO as the Health Council Advisory Committee to the PTA Comprehensive Health Education Project.

In New York, PTA members in Nassau/Suffolk County school districts set as their objective the acceptance of the local PTA-established health council as the advisory body for the school health education planning activities of the local health systems agency.

Sometimes a group's deliberations get bogged down. Other times, a group may plow through an idea without careful thought. In either case, if you sense the need to improve on an idea or look for other options, go around the group, and ask:

a. "If we did this, what would we hope to achieve? What purpose would it serve?"
b. In response to the replies, ask: "Why would we want to do that?"
c. and finally, "What else could we do that might serve that purpose?"

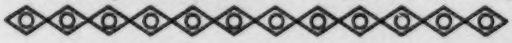
4. Occasionally, a person or group is able to think of ideas by developing different ways of looking at what's wrong. So often there are prescribed or established ways of doing things. For every established way, there are a series of assumptions that are made or points that are taken for granted.



Here are three common types of assumptions that are pitfalls to setting objectives:

a. time and cause: "because B happened after A, B must have been caused by A"
b. more is better: "all we need to do to make it work is provide more money—time—people—space."
c. post and position: "because a person holds a post/or job, his position on an issue must be . . ."

New solutions demand new ways of looking at the problems. This means questioning any assumptions being made, asking the right questions, and seeing the problem through the eyes of others. In Georgia, for example, the PTA held a statewide teenage health conference to obtain student viewpoints and ideas on what might be done to improve health education, and on how to go about it.



5. Sometimes ideas come from examining the resources at hand, or the opportunities that time or people can provide. To a certain extent, your steering committee makeup will predetermine certain resources (in the way of expertise) available.

There is a tendency to start with problems to define the objectives of our programs. Instead of thinking in terms of problems, however, it may be helpful to think in terms of opportunities. If we look only for "problems," we may miss some valuable opportunities close by.

Many of the State Projects took stock of their resources to define their program objectives. In Pennsylvania, for example, community libraries were used as health information centers as well as centers for planning, promoting and conducting health education activities. The California Department of Education considered the PTA Comprehensive Health Education Project almost as an integral department and provided the resources and consultation to produce audio-visual materials and training. Likewise, the New Mexico PTA developed a community action manual, and applied to the New Mexico Public Health Association for a grant to publish it. Also in that state, additional objectives were set based on the University of New Mexico's offer of in-service credit and job up-grading for health education teachers and school nurses.

To help the committee shift its thinking from problem solving to opportunity searching, try these techniques:

- List all the group's opportunities or resources, using the following suggested categories:
  a. abilities and interests of group members
  b. untapped community resources, such as people's talents and knowledge, contacts, money or time
  c. ideas and visions of a better health education program in the schools or community.
- Review your problem lists to look for the "other side of the coin"—positive outcomes that might be achieved.
- Imagine your group is very successful and influential and then note what positive changes could be accomplished.
- See what ideas come out of combinations of program suggestions, resources and interests.

development

D. Develop and Choose Project Ideas

Now that you have an expanded set of program objectives on hand, it is time to enter another narrowing process—that of selecting the most appropriate ideas and developing them into feasible activities or strategies. Oftentimes, these two processes—selecting and developing program ideas—are carried out simultaneously. Choices can't really be made from among alternative ideas until they have been developed. And, conversely, in developing an idea, priorities automatically become realized. Nonetheless, there are certain steps you can take to develop your program ideas (prior to implementation) and to select the ones best suited to your goals and objectives.

The objectives you have set probably have spurred project ideas that are in the form of nuggets like "organize a workshop" or "produce a multimedia program." The next step is to develop these rough statements into polished ideas. This serves two purposes:

1. Everyone will have approximately the same notion of what is being considered.
2. It provides an opportunity to anticipate problems or think of improvements.

The point is to take an abstract idea and make it real in people's minds—before it happens, and before the steering committee has to choose one alternative over another. Here are some ways to do this:

- If your idea involves a conference or workshop activity, draw a sketch of the physical setting and arrangements you will need.
- If your idea involves a series of steps, then develop a rough schedule of events to flesh out the concept and identify the sequence and relationships of the steps.
- If your idea involves collaboration, campaigning or confrontation with other people, write a script of the probable conversation or employ roleplaying to determine how outsiders might perceive your idea.
- If your program idea involves many people, time, money or other resources, develop a rough implementation plan. Take a systematic approach by incorporating the following information:
  - number (and names) of people involved
  - starting and ending dates
  - average amount of time per person
  - types of tasks involved
  - costs
  - schedule of tasks
  - means for evaluating success.
- If your program idea involves some inherent risks (as noted by any negative comments of the steering committee), develop a contingency plan.

In selecting between various alternatives for programs, there are a number of considerations that may help:

- One criterion for selecting a program from an array of ideas is to determine how closely it "matches" or supports your group's goals and purpose.
- Desirablility is another criterion, particularly if you're considering three or four ideas that seemingly have equal merit. Stating and rating the pros and cons of each idea would be one way to sort out preferences.
- Feasibility is a very important criterion. By comparing the resources needed for a particular program with the resources available and likely, you can begin to rate your program ideas in a pragmatic manner. This initial feasibility test should take into account:
  - time (overall) and for particular individuals
  - costs
  - cooperation of other organizations
  - community support
  - physical space
  - other factors

- Potential complications or risk is another criterion to use in choosing project ideas. "Zap analysis" is another term used to convey the idea of risk—consideration of things that could pop up and upset your program. One way of conducting this search is to play the Devil's Advocate. Rate each of the risks in terms of how likely or disruptive they may be, and then decide what can be done if your ideas are "zapped" regardless of how well you plan.

California and Georgia applied the "forced field analysis" technique to determine the factors that are both "going for" and "going against" attainment of the project objectives. In California, this activity was a training device in preparing PTA leaders to present their project goals to school boards.

The leader reviews the short term goal of the project (enactment by local school boards of policies and/or resolutions supporting comprehensive health education in their school districts as a result of *planned* presentations by PTA members) and states that some factors will be "going for" attainment of the goal and some factors will be "going against" attainment of the goal.

Leader asks participants to work in groups of four to seven; however, to start the activity each participant is asked to list one or two factors he or she believes may be "going for" attainment of the goal and one or two "going against" attainment of the goal. After two to three minutes of the individual listing, each group is given large sheets of newsprint and asked, as a group, to list all the factors they can think of "going for" and "going against" attainment of the goal. At the end of 10 to 15 minutes, each group tapes its lists on the wall and shares the items it has listed. The leader calls attention to the fact that many of the factors "going for" attainment of the goal offset those "going against"; however, the trainees must be ready to discuss the various factors as questions will be raised by school board members and others. (Note: At the end of the activity, a composite list of "factors for" and "factors against" developed in prior training sessions is distributed to participants.)

E. Implement Project Activities

Once you have decided upon your project goals and objectives, specific strategies for building support systems can be designed to implement the awareness activities that support those goals and objectives. Certain activities are more effectively implemented and managed by certain kinds of organizational structures. For example, leadership training was most effective in the states of California and Colorado where the geographical barriers of distance and terrain precluded a simple centralized facilitating structure. Appendix F shows the variety of structures devised by the project and adopted by the demonstration states along with the activities undertaken for each of these structures. None of the activities was exclusively tied to a specific structure, nor is any structure shown in Appendix F all-inclusive in the activities listed. In fact, all of the states incorporated a combination of activities. For example, Indiana's approach is shown in Appendix G.

The decision about which activity or combination of activities your project should take is but one step toward success. Strategies for implementing these activities may be helpful, not only in terms of initiating your program but also in effective achievement of objectives and efficient use of resources. Some strategies to consider are gaining support and managing the project.

Gaining Support

Don't go it alone is the message here. There are sources of assistance that can help the steering committee carry out its objectives. "Resources" is an overused word these days, but what it means here is the people, organizations, materials and money at both state and local levels that you might use to implement your project.

- **People:** Your project may need outside volunteers with useful information, skills, judgments, insights and contacts. Your committee is made up of such individuals, and the committee sought such individuals to help with the project planning steps.

Now it's time to look beyond your committee for individuals who could help implement your ideas.

Bringing in resource people for the health education project involves some special attention. As long as you are not asking for very much time from any one individual, recruitment is usually not a problem. The difficulty is getting them to do what needs doing. Part of the difficulty is in having an accurate perception of what particular talents an individual or their organization has to offer. Consider persons on the basis of what skills and/or experience they bring to the group, what they could teach to others, what they would be interested in learning, and what skills and abilities they would like to use, even though they may not be immediately needed.

The CS/CHE Project chairmen found it most useful to give the resource person specific guidelines, preferably in writing. He or she should know such things as:

a. the nature of the project and what the group's expectations and needs are for completing the project
b. exactly why he or she was chosen
c. what information, skills, etc. the steering committee is seeking; examples of situations, conditions or problems with which the person would have to contend
d. the manner by which the information or skills are to be communicated (lectures, role-play, case study, etc., or some combination)
e. the time and support to be offered to the person by the committee
f. the division or sharing of responsibilities
g. the previous accomplishments of the committee, or how it got to where it is today.

Before engaging any individual in the project, make sure there is an understanding of whether fees, honoraria, donations or other payments for services are expected by that individual (regardless of whether that person is a volunteer, official or professional). Also, if your committee is able to offer expenses to cover travel, room, board or materials used, make sure this is understood by the person who is asked to serve.

• **Organizations:** Too often organizations exist unto themselves, out-of-touch with other groups that share their concerns. Sometimes this is a matter of the group maintaining a "low profile," sometimes it is the result of a group feeling unprepared to lay their cards on the table before another organization. But there are ways to track down other organizations and most often these groups would welcome being recognized and approached for help. Groups can be:

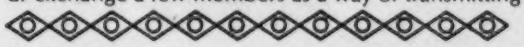
a. sources of success stories (ideas about what works and what doesn't)
b. sources of information (to avoid rediscovering the wheel)
c. providers of training for a particular activity or task
d. partners in carrying out your project activities
e. endorsers of your project goals, objectives and actions.

The State Projects found these resources helpful: the Yellow Pages (under Health/Education/Social Service Agencies); the town clerk's office or city manager's office; the public library; elected representatives' offices; the League of Women Voters and other community service organizations; citizen information services or community resource centers, including walk-in and telephone information-and-referral services; local social service directories; state and regional offices of national organizations; and national clearinghouses for health education. (See Appendix H)

Contact with other organizations can be mutually beneficial. The collaborative efforts of the State Projects varied with the types of activities undertaken. Regardless of the activity, however, there are some initial actions to consider in forming an alliance. For example, someone on the steering committee may want to:

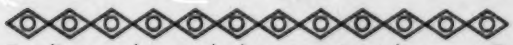
a. observe their meetings or projects to learn how they go about achieving their goals

b. talk with members of the other groups to gather information, ideas for strategies and names of contacts
c. plan and carry out a joint information and/or training session
d. exchange a few members as a way of transmitting skills back and forth.



• **Materials:** Appendix I lists materials produced as prototypes and distributed by the CS/CHE State Projects. These state prototype materials, as well as any portion of this manual and its appendices, may be reproduced for your purposes, with appropriate credit.

• **Money:** One of the main points of this manual is to help community groups recognize the importance of volunteer leadership in developing ideas and turning them into useful projects that affect change. However, costs are going to be incurred. Groups should realize that time, wasted on a project because the group lacks some resource essential to success, is also worth money. So it may be "penny wise and pound foolish" to avoid spending a few dollars on materials or even hundreds of dollars for consultant services when the success of your group is at stake.



Funding can be sought from a variety of sources. Regardless of what organizations are approached, the committee should develop some form of proposal that specifies the project's purpose, objectives and general financial needs. Some organizations provide guidelines for developing proposals. In approaching organizations, recognize that there are appropriate times during which they may be more receptive: e.g., before the start of their budgeting cycle.

In the search for money, the committee might investigate:

a. influential community leaders, such as political appointees and elected officials, bankers and church leaders
b. foundations (local, state and national)
c. government sources (local, state and national)
d. community organizations, such as local businesses, clubs, civic and fraternal organizations, social service agencies, hospitals, churches and professional societies
e. corporations with financial resources earmarked for community programs. In Georgia, for example, the Sears, Roebuck and Company printed the PTA's directory of resources and reproduced slides for the project.
f. bequests designated by wealthy individuals to specific areas of interest
g. self-generating fund-raising activities, such as benefit concerts, bake and garage sales, bazaars, carnivals, and the exchange of services (as another type of in-kind contribution).

A major source of resources for most of the State PTA Projects was in the form of in-kind contributions. Some organizations, state agencies and colleges or universities do not have or cannot give money directly to projects, but nonetheless are enthusiastic and willing to assist such projects through facility space, A-V materials, donated time of employees, equipment and services such as printing and distribution of materials. Always acknowledge, publicly, contributions received.

In-kind services can reach sizeable amounts. A review of all the CS/CHE Project States shows that for every $4 spent to achieve project goals, only $1 was in the form of direct payment from the National PTA contract, while $3 were generated locally in the form of in-kind contributions.

Managing the Project

Once a specific project is chosen, and support for implementing it sought, the committee will need a method for allocating responsibilities and making sure that everything gets done on time. The Projects found that one way to limit the role confusion and enforce deadlines was to involve workers early in the planning process.

This provided an opportunity for everyone to have an equal say in how responsibilities are allocated and to gain a sense of the program as a whole.

The project chairman should resist both the inherent and external pressures to shoulder responsibility for *all* the project tasks. Project leaders in a number of states recognized this trap and avoided its consequences by:

- assigning tasks and delegating authority for those tasks to as many individuals on the committee as possible
- recognizing the short-term nature and eventual completion of the project
- sharing their insight, experiences and frustrations with others on the committee
- familiarizing another key person on the steering committee with all aspects of the project so that person could fill in should the leader's absence from project activities be required.

Assignment of Tasks: If the nature of your project is simple, in that there is little or no interdependency among tasks, assignment of tasks may be handled in a brainstorming session in which each of the activities or tasks are dealt with by asking for suggestions about deadlines and responsibility. Once all suggestions are on the floor, try to develop a rationale for each. If there is confusion and/or disagreement, ask each person to explain his or her concerns. This process of "checking out" areas of disagreement usually leads to acceptance and/or compromises.

If your project is more complicated, with tasks that are interdependent or that require interlocking steps to accomplish, then you might want to employ one or more approaches to timelining. One popular approach is the PERT diagram (Program Evaluation and Review Technique). Here's how to use this approach.

1. Brainstorm the tasks involved in your project as thoroughly as possible, writing each one on a slip of paper.
2. Stretch some shelf paper (or other roll-paper) on a tabletop or floor and mark off weeks or months along the length of the paper, leaving enough space to spread your task slips along the paper.
3. Group the task slips by type (e.g., publicity, fund-raising, production of materials). These are the "tracks" of activities that are closely related.
4. Take each group of slips and arrange the tasks in the appropriate time sequence. Estimate how long each task will take to complete and write that time in the bottom right corner. Then position each slip on the time grid. Do the same for all groups of slips. Add more task slips as you think of them.
5. Think about how one "track" relates to another and to the specific tasks that are interdependent upon one another from different tracks. What you will come up with is a timeline that looks like a railroad switching yard. Every time one track needs the information or completion of another track, connect them with arrows.
6. Stand back and look at what you've created. Does it adequately show all the specific tasks to be accomplished in the sequence needed with realistic estimates of the time required and the connections between tasks and tracks? See that each portion of the timeline has about the same level of detail.
7. Assign individuals to each of the tasks and rewrite the tasks as events that convey who does what and by when.

Deadlines and Accountability: All of your planning efforts are futile if the group cannot meet its deadlines and specific activities do not get done on time. Here are some ideas used by the State Projects for improving accountability:

- Make sure everyone knows who's doing the job, and that person(s) can and will do it.
- Make sure each job is stated so that the group will know when it is done.
- Make sure the deadline is clear; write it down, preferably on a timeline on the wall.
- Choose the best reporting pattern for your group.
- Think through the consequences of not finishing a task (someone else is delayed; the project can't happen, etc.). Timelines can help people see the consequences of a missed deadline.

- Try to avoid frequent meetings to "discuss the accountability problem"; they may become a convenient excuse to procrastinate ("I really want to finish with this job but . . .").
- Discuss as a group what types of pressures and reminders help each individual.
- "External" deadlines—such as a printer's schedule, an event announced in the mass media, a date when the public expects to hear the results--can help a group get going.

Reports and Records: A most important aspect of project management is the maintenance of chronological records of all financial transactions, meeting proceedings or minutes, progress reports, policy statements, procedural guidelines, publicity materials, verbal communications and written correspondence. Recordkeeping often is viewed as a task that is tedious, time-consuming and thankless. Nonetheless, the Project chairmen realized the important reasons for doing it. First, it provides a track record of progress and continuity for the committee members to use in gaining a sense of accomplishment. Second, it provides information needed by anyone on the committee who is asked to report on the project. Third, if funding for the project is required, orderly and timely records will provide the information needed to prepare a budget, as well as give your project a sense of validity and credibility in the eyes of your funding sources. The person chosen to keep the project records, obviously, should like to work with details, and be highly organized in his or her work habits. The task may be tedious and time-consuming, but it need not be thankless. Give that person a pat on the back once in a while.

Measuring Committee Progress: Another important aspect of project management is establishing a feedback mechanism to provide information needed to better steer the course of the committee as it manages the project. The records and reports generated throughout the project's life can supply much of the information needed to assess committee progress. Some of the measures reported by the PTA chairmen for you to consider are:

- attendance at meetings
- intensity and participation in discussion
- levels of motivation and enthusiasm in carrying out committee activities
- coverage of the committee's activities by the media
- support statements from politicians and organizations
- contributions (monetary or in-kind services)
- adherence to the assignments and deadlines established in the project timeline
- inquiries about the project from other organizations
- smooth transition of committee leadership and membership

F. Measure Project Progress and Outcomes

Not too many years ago, evaluation of social service and community-related projects was considered an activity that was either not necessary (after all, the results were self-evident), or else too technical or scientific in nature to be done by anyone other than academicians. With the growth of social accountability (particularly for projects that used outside sources of money), evaluation was then tagged onto the program. Now it is considered one of the steps *inside* program planning, and for a few good reasons:

- It provides information for decision making.
- It measures the progress of your group toward achieving its goals.
- It pinpoints particular activities or program sections that could be improved.
- It helps clarify "fuzzy" goals and objectives.
- It can aid your group in planning future programs.

A preliminary step in designing an evaluation process is to establish the purpose of doing an evaluation and the criteria that should be used to fulfill the purpose. A proper distinction should be made between two levels of project evaluation: one aimed at the process used to work toward the goal (the workshop, slide presentation, media spots, etc.); and the second aimed at the effectiveness of the project in terms of outcomes and impact (e.g. community response and action taken after exposure to the project in achieving the goal).

One aspect of process evaluation was covered in the previous section: how well the steering committee worked in carrying out its process of implementing the project. Another aspect of process evaluation is how well the project objectives were met. In this sense, evaluation is a comparison of the record of accomplishments against that list of hopes and intentions which were formulated as objectives. Evaluation of this process can be measured in terms of how far or how much (quantity) and how well or how rich (quality). The sum of these two represents the "value" (as in "evaluate") of the project.

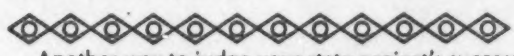
Some of the State Projects' objectives were met through the development of prototype products (A-V materials, booklets) or through events (workshops initiated, television appearances). Each of these products or events can be evaluated by using the following techniques:

- informal interviews
- questionnaires
- observations
- documents (e.g. newspaper articles)
- physical evidence (inventories, products)
- personal records or diaries
- tests (opinions, attitudes, knowledge, values, etc.) conducted by professionals.

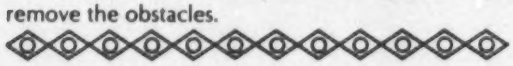
Using any of these techniques, an activity can be evaluated by comparing responses immediately before and after an activity takes place or at any predetermined future date. Certain approaches to evaluation are more easily quantifiable than others; but do not dismiss the use of success indicators which do not lend themselves to numerical ratings.

In judging the outcome or impact of a project, the measures of how far, how much, and how well still work, but they should be applied against the factors singled out (under legislation, education, communication and organization) in the assessment phase of the project. In this sense, evaluation is a comparison of changes that have occurred since the project began. One of the pitfalls that State Projects encountered with this line of evaluation was the assumption that the changes which occurred were caused by, either directly or indirectly, the Project's progress or accomplishments. This assumption may or may not be valid, but it would take professional studies to demonstrate the cause-effect relationship between a project's goals and their impact. Nonetheless, various State Project plans incorporated the following general kinds of questions—measures of their Project's effectiveness:

- Approximately how many local committees have been established to advocate health education in the communities?
- What has been the response of the state board of education and the state department of education and health agencies?
- Has the state education agency and authority proposed any alteration of their policy regarding the status of health education in the state curriculum?
- Have local school policies changed?
- What has been the prevailing response of PTA groups toward the project?
- Can the project ideas be adapted by other groups who wish to advocate health education? If so, how many groups have asked?
- What future goals have been set by the state PTA health education steering group as a result of the impact of this project?
- Have other organizations offered their own evaluations on the project's impact?



Another way to judge your state project's success at the local level is to encourage local action plans and statements of commitment. In Florida, North Carolina, Ohio and California, the State PTA Project teams met with project facilitators at the local community level and mutually decided what "success signals," either individually or as a group, could be adopted. A list was compiled and at designated times during the project's course was reviewed to see how many of the criteria were being met. Discussion and critique focused on those areas where little or no progress had been made. Using this technique, strategies can be designed or adjusted to remove the obstacles.



Signs of Impact

Beyond the immediate goals achieved by the State Projects, additional benefits have spun off as communities and states respond to the Project efforts. The increased involvement of parents has had positive impact on the scope and quality of health education programs, state health systems agencies, health maintenance organizations and professional groups with an interest in school and community health issues. In all of the Projects, parents have pressed for the planning and coordination of resources for anticipated health education needs, rather than reacting to current community crises in a hit-and-miss fashion.

New Mexico PTA jointly prepared a community action manual with the state Public Health Association that has been published and distributed by the Bureau of Health Education, DHHS. As a result of the New Mexico project, Albuquerque public schools will require K-12 comprehensive health education for all students, beginning 1980-81.

The Oakland (California) School Board established a health education requirement for high school graduation.

Plans are underway to translate all phases of the California PTA *Health Education: Awareness and Action Project* into Spanish. This includes the project brochure, the cassette that is coordinated with the slides, training materials, and descriptions of joint commission cooperation and of youth involvement. A packet will be developed that may be used as a tool for future bilingual conferences or conferences presented in Spanish.

Arkansas PTA now has a training model in sex education for parents, administrators, teachers and nurses; this was developed in project workshops involving 25 school districts in Arkansas.

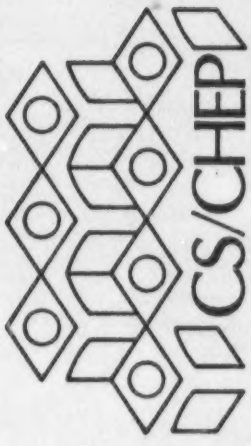
Health systems agencies (HSA) have made health education a top priority in New York, New Mexico, Indiana and Idaho. PTA representatives sit on HSA committees and school health task forces.

In an unprecedented action, a local government in Pennsylvania allocated revenue sharing funds for health education. Colorado received $1,000 from the Department of Education for a drug education project.

As a result of the successful "track record" established with the CS/CHE Project, the Georgia PTA has received a contract in the amount of $30,000 from the State Board of Education to develop a state plan for the coordination of parent, faculty and student involvement in the school food service program in Georgia schools. They have also been awarded a Federal grant of $58,060 for a one year Family Life Education Project.

In Idaho, a "Grass Roots Coalition" was formed to deal with teenage alcohol and drug use, and in Ohio, the PTA is now represented on the State Planning Committee for Health Education.

In other states, Project ideas have been adopted. For example, state and local funds have been generated in Massachusetts, South Carolina and Florida to adapt and produce the health education slide/cassette programs developed by the Georgia and California projects. Wisconsin PTA was awarded $7,000 by the State Prevention and Wellness Commission for health education promotion; and the Alaska PTA has received $30,000 for a student health education project based on the CS/CHEP Student Health Education Forums.



Epilogue

The purpose of this manual is to show how the experiences gained by the pilot and demonstration states within the CS/CHE Project can be used to plan community awareness and support systems for comprehensive health education. In suggesting a process described for accomplishing this goal, there is an inherent risk of depersonalizing the activities, e.g., the *committee* decided; the *problem* was; the *project* did; and the *support system* was formed.

In reality, of course, committees don't decide, people on the committee decide; problems and opportunities don't exist without people; projects don't act, people carrying out projects act, and the goal of support systems is meaningless unless people provide support.

Just as you give proper attention to involving the appropriate kinds of people in designing your project, so too should you be aware that appropriate groups of people are necessary for the project's success. The first group is your own organization. Without an organizational base of support, your project will have a difficult time of being accepted at the second level—the community within which your project is to blossom. Without the community base of support, the target population of your project will not perceive its importance.

Good luck in your endeavors to see that **Health Education Matters!**

III. Appendix

Reference on page	Content
28	**A.** Comprehensive School Health Education Program Resolution of the National PTA
29	**B.** The School Health Program
30	**C.** State School Health Education Programs
32	**D.** School Health Educator Certification
33	**E.** Assessment Tools Used by State PTA Projects
34	**F.** Organizational Support Structures
35	**G.** Activities Chart
36	**H.** Resources for School Health Information
37	**I.** State PTA Project Materials

Appendix A Comprehensive School Health Education Program Resolution

Adopted by the 1973 Convention of the National PTA

The National PTA is vitally interested in the teaching of health in the public schools. The school health curriculum has been fragmented into separate programs in such areas as drug abuse, venereal disease, environmental health, and family life education. Many local school districts have combined health education and physical education programs. There is a need for a comprehensive program of health instruction in our schools which will meet the total needs of all children and youth, therefore be it RESOLVED:

That the National PTA lend its full and active support to the development of an identifiable comprehensive school health education program to include dental health, disease control, environmental health, family life, mental health, nutrition, safety, and substance abuse, and that the National PTA reaffirm the 1970 position statement of the National PTA Board of Managers relating to Federal and State Support to Comprehensive School Health Education Programs* while giving wide publicity to the similar position statement adopted by the Big Six (National Congress of Parents and Teachers, American Association of School Administrators, Council of Chief State School Officers, National Association of State Boards of Education, National Education Association, and National School Boards Association); and be it further RESOLVED:

That the National PTA urge its state branches to cooperate with their state departments of education and health, and with local school districts, to develop such a program.

*Federal and State Support to Comprehensive School Health Education Programs (excerpt)

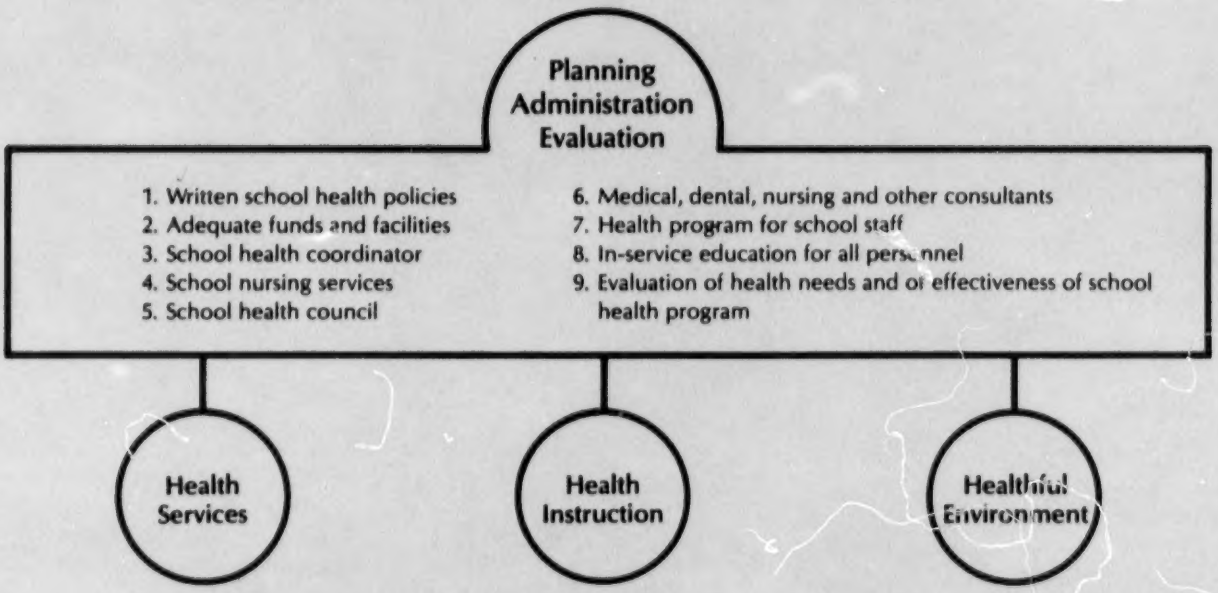
Adopted by the National PTA Board of Managers, January 29, 1970

The National Congress of Parents and Teachers has consistently supported the inclusion of various health topics in the school curriculum. Resolutions and programs at both national and state levels have indicated PTA concern for alcohol and drug abuse education, smoking and health, physical fitness, mental health, family life and sex education, the need for continuous health supervision, consumer health, venereal disease education, nutrition, and accident prevention. Other health issues have received attention periodically through the years.

State laws and state board of education regulations (either permissive or mandatory) influence the nature of educational programs offered in schools. Some states have recently revised outmoded laws and regulations to meet current needs, including the provision of definite time in the curriculum and qualified leadership. Funding from governmental agencies at federal, state, and local levels also has great bearing on the quality of educational offerings. Often such funding has not included the subject-matter area of health as part of the instructional program.

The National Congress of Parents and Teachers supports the concept of comprehensive school health education programs and believes these programs should be given higher priority at national, state, and local levels. It urges educators to develop such programs and governmental agencies at all levels to provide the necessary funds. Further, it urges members of Congress, the Secretary of Health, Education and Welfare, the U.S. Commissioner of Education, state departments of education, and local school districts to establish higher priorities for these programs on a level comparable to other curricular subjects.

Appendix B The School Health Program


Planning
Administration
Evaluation
1. Written school health policies
2. Adequate funds and facilities
3. School health coordinator
4. School nursing services
5. School health council
6. Medical, dental, nursing and other consultants
7. Health program for school staff
8. In-service education for all personnel
9. Evaluation of health needs and of effectiveness of school health program
Health Services
Health Instruction
Healthful Environment

- Readiness programs including preschool health screening and assessment of emotional readiness
- Health appraisal by observation and periodic examination
- Health counseling for physical and emotional problems for pupils and families, with referral and follow-up
- Consultation with teachers on physical and emotional problems encountered and recommendations regarding participation in physical education, special education programs and other school activities
- Emergency policies, facilities and first aid
- Immunizations, tests and communicable disease procedures
- Dental examinations and fluoride applications
- Cumulative records including health, accidents and social development

- Sequential health curriculum:
  a. broad program goals
  b. health instruction with teaching-learning objectives for all grade levels
- Adequate teacher preparation and in-service
- Resource materials and consultation for teachers
- Health education for parents and other adults
- Education adaptations for handicapped children
- A comprehensive physical education program

- Friendly staff and pupil relationship
- Healthful daily schedule
- School site of adequate size, location and safety
- Construction standards for size, sanitation, safety features, lighting, furniture, acoustics, heating and ventilation
- Safety inspection, drills and patrols with pupil planning and participation
- Proper school maintenance
- Adequate and safe physical education and recreation facilities and staff
- Food Service programs that meet standards
- Safe bus operation

From *Physician's Guide to School Health Curriculum Process*, 1980. Permission to reprint granted to the National PTA by the American Medical Association, Chicago, Illinois 60611

Appendix C State School Health Education Programs

State	Health Education	Drugs Tobacco Alcohol	Venereal Disease	Nutrition	Mental Health	Environmental Health	Family Life/ Sex Education	Personal Health
Alabama		M	Semester of health education required for graduation.					
Alaska	G		Same as Kansas					
Arizona		O		O	O	O	O	
Arkansas		M	M		M	M		
California	G	M	M	O	O	O	O	M
Colorado	G	M						
Connecticut		M						
Delaware	G	M	O	O	O	O	O	O
District of Columbia		M	M	M	M	M	M	M
Florida	C	M	M	M	M	M	O	M
Georgia		M	O	O	O	O	O	O
Hawaii	C	M	M	M	O	M	M	M
Idaho		M	O	O	O	O	O	O
Illinois	C	M		M	M	M		
Indiana		M						M
Iowa		M	M					
Kansas	Health education is not required; however, one unit of physical education is required for graduation of which one half unit							
Kentucky	G-E	M		O	O	O	O	
Louisiana		M-S	O	O	O	O		O
Maine	G	Subject offerings are option of local school district.						
Maryland	G	M					M	
Massachusetts				M	M	M		
Michigan	G	M	O	M	M		M	O
Minnesota		M	O	O	O	O	O	O
Mississippi	In grades 1-12; health instruction is required, but no specific requirements.							
Missouri		O		O	O	O	O	O
Montana	G							
Nebraska	G							
Nevada	One half unit of health education is required for graduation.							
New Hampshire		M	M	M				
New Jersey	G	M-S	O	O	O	O	O	O
New Mexico		O	O	O	O	O	O	O
New York	C-E	M		O	O	O		
North Carolina	G-E	M	O	O	O		O	O
North Dakota		M						M
Ohio		M	M					
Oklahoma	Although no separate program exists, health education content is taught in conjunction with other subject areas.							
Oregon		M						
Pennsylvania		M						
Rhode Island		M	One hundred minutes of instruction in health and physical education per week is required					
South Carolina	C	M	O	O	O	O	O	O
South Dakota	No formal program at state level.							
Tennessee		M	M	M		M		
Texas	G	M						
Utah		M	O	M	M	M	O	M
Vermont		M						
Virginia	C	M		M	M	M		M
Washington		M						
West Virginia	Instruction in physical and mental health is required at the junior high and high school levels.							
Wisconsin	G	O			O			O
Wyoming	Health education is taught according to local education mandates.							

M = Mandated O = Optional/Permissive S = Secondary School Level
E = Elementary School Level
G = General; local option for selection of content and when offered.
C = Comprehensive; specified content areas for each grade level.

Unless otherwise noted, programs refer to both elementary and secondary levels.

Anatomy Physiology	Safety	First Aid	CPR	Diseases	Community Health	Dental Health and Oral Hygiene	Health Careers	Consumer Health	Growth and Development
			M						
O	O	O		O	O				O
	M	M		M		M			
O	M	M	M	O	M	O	C	O	O
M	O	O		M	O	O	O	O	
	M	M		M	M	M	O	M	M
M	M			M	M	M	M	M	M
O	O	O		O	O	O	O	O	O
	M	O		M	M	M	M	M	M
O	O	O		O	O	O	O	O	O
M	M			M	M	M	M	M	M
	M								
	M			M					
may be health education.									
	O			O	O				
O	O	O		O	O	O	O	O	
M					M	M		M	
	M	O		M	O	M		O	O
O	O	O		O	O	O	O	O	O
	O	O		O	O			O	
O	O	O		O	O	O	O	O	O
O	O	O		O	O	O	O	O	O
	M	O		O		O		O	
O	O	O		O	O	O	O	O	O
M				M					
	M-E								
for all students, K-12.									
O	O	O		O	O	O	O	O	O
M	M	O		M	O	O	O	M	M
	M	M		M				M	M
O	O								

School Health in America
2nd Edition, 1979

Permission to reprint was granted to the National PTA by the American School Health Association, Kent, Ohio.

Readers are advised to check with state organizations concerning changes in requirements or personnel as a result of pending legislation that may have become law since the completion of this second edition, March 1979.

Appendix D School Health Educator Certification

State	Health Education	Health, Physical Education	Comments
Alabama			Must have minor in health, physical education, and/or recreation
Alaska			Teacher certification only
Arizona			Teacher certification only
Arkansas	X		17 semester hours of health education
California	X		A health science specialist instruction credential has been established
Colorado			Teacher certification; additional requirements may be set by local school district
Connecticut	X		
Delaware	X		
District of Columbia		X	
Florida	X		
Georgia	X	X	
Hawaii	X	X	
Idaho	X	X	
Illinois	X		
Indiana	X		
Iowa			Teacher certification only
Kansas	X		18 hour semester requirement
Kentucky	X		
Louisiana			Listed as Health and Safety Education Certification
Maine			Teacher certification only
Maryland	X		18 semester hours in health education
Massachusetts	X		
Michigan	X		
Minnesota	X	X	
Mississippi		X	
Missouri	X		
Montana	X	X	
Nebraska	X	X	
Nevada			Major or minor in health education
New Hampshire	X		
New Jersey			NASDTEC Standards
New Mexico	X		
New York	X		
North Carolina			Recommended guidelines for professional preparation
North Dakota			No requirements
Ohio	X		
Oklahoma		X	
Oregon	X		
Pennsylvania	X		
Rhode Island		X	
South Carolina	X	X	
South Dakota			No requirements
Tennessee		X	
Texas	X	X	24 semester hours in health education
Utah			Major or minor in secondary education in health
Vermont			Teacher certification
Virginia	X	X	
Washington	X	X	
West Virginia	X		
Wisconsin	X		Separate certification for health and physical education
Wyoming	X		Minor, major or master's degree in health education

School Health in America
2nd Edition, 1979

Permission to reprint was granted to the National PTA by the American School Health Association—Kent, Ohio

Appendix E Assessment Tools Used by State PTA Projects

"An Assessment Instrument for Comprehensive School Health," developed by Indiana Congress of Parents and Teachers, CS/CHE Project, 2150 N. Lafayette, Indianapolis, IN 46222 with consultation of Northern Regional Service Center Staff, Indiana Department of Public Instruction.

A Guide for Improving Health Education Instruction Grades K-12, Rev. 1979, also *A Self-Appraisal Checklist for School Health Programs* (revised edition), Ohio Department of Education, Health, Physical Education and Recreation Section, 65 South Front Street, Columbus, OH 43215 or Ohio Department of Health, Health Education, P.O. Box 118, Columbus, OH 43216

Checklist on School Health Programs for Demonstration Schools, (Joint Committee on School Health: Arkansas Department of Health, 4815 W. Markham, Little Rock, AR 72201, Arkansas Department of Education, Capitol Mall, Little Rock, AR 72201.) also *Handbook for Health Education in Arkansas Schools*, Rev. 1979.

"Colorado School Health Guidelines" 1977 ($3.00) Joint Publication of the Colorado Department of Education, 201 E. Colfax, Denver, CO 80203 and Colorado Department of Health, 4210 E. 11th Avenue, Denver, CO 80220.

"Comprehensive Health Education Program Status Report of Activities," FY 78-79, State of Florida Department of Education, Tallahassee, FL 32304.

Criteria for Evaluating the School Health Education Program, 1977, ($.65) also *The Health Instruction Framework for California Public Schools* ($1.35) order with remittance from: California State Department of Education, P.O. Box 271, Sacramento, CA 95802.

Framework and Course of Study of Health Education Curriculum, Division of Health, Safety and Physical Education, State Department of Public Instruction, Raleigh, NC 27611.

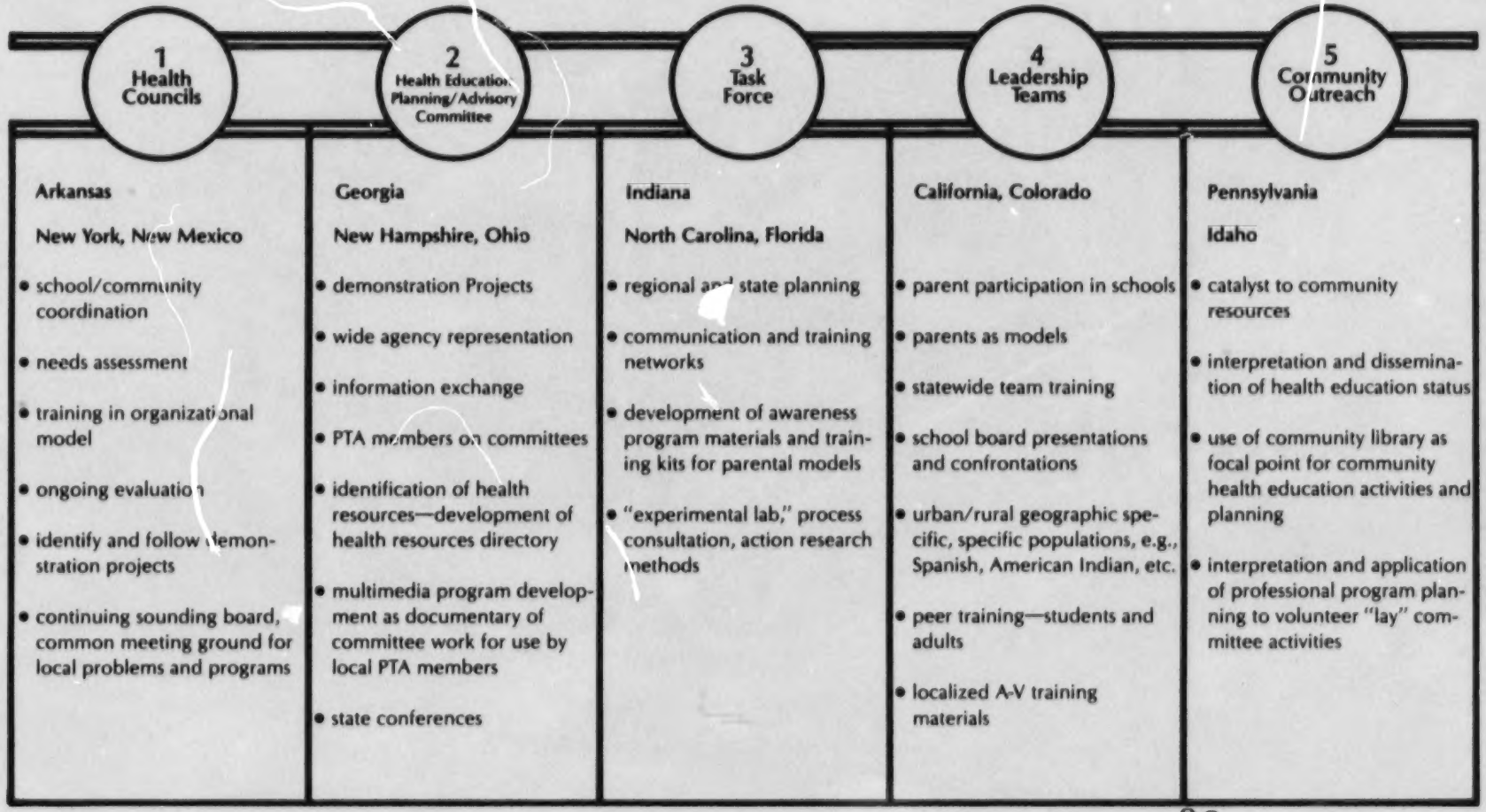
'Getting to Know Me' Health Education Program for Idaho Public Schools (grades K-3 and grades 4-6); *'The Way I Am' Health Education Program for Idaho Public Schools* (secondary) Idaho State Department of Education, 650 West State Street, Boise, ID 83720.

The Georgia Health Education Study, a Summary Report, University of Georgia Department of Health and Safety, Athens, GA 30602, also *"Building a Better You," Health Education Curriculum*, 1978-79. Elementary and secondary levels ($2.50 ea.) Department of Education, Room 202, Education Annex, 156 Trinity Avenue, S.W., Atlanta, GA 30303, also: *Georgia's NEW Health Outlook*, digest report on the Community Health Task Force, Division of Physical Health, Department of Human Resources, 1976. Write Director, 47 Trinity Avenue, S.W., Atlanta, GA 30334.

"Nutrition Guidelines," New Hampshire Department of Education, Food Nutrition Services, 105 Loudon Road, Concord, NH 03301.

Strand Guides in Health Education, available outside New York State via ERIC Document Reproduction Service (EDRS) Post Office Drawer O, Bethesda, MD 20014.

Appendix F Organizational Support Structures


1 Health Councils
2 Health Education Planning/Advisory Committee
3 Task Force
4 Leadership Teams
5 Community Outreach
Pilot
Demo
Awareness Activities
Arkansas
New York, New Mexico
• school/community coordination
• needs assessment
• training in organizational model
• ongoing evaluation
• identify and follow demonstration projects
• continuing sounding board, common meeting ground for local problems and programs
Georgia
New Hampshire, Ohio
• demonstration Projects
• wide agency representation
• information exchange
• PTA members on committees
• identification of health resources—development of health resources directory
• multimedia program development as documentary of committee work for use by local PTA members
• state conferences
Indiana
North Carolina, Florida
• regional and state planning
• communication and training networks
• development of awareness program materials and training kits for parental models
• "experimental lab," process consultation, action research methods
California, Colorado
• parent participation in schools
• parents as models
• statewide team training
• school board presentations and confrontations
• urban/rural geographic specific, specific populations, e.g., Spanish, American Indian, etc.
• peer training—students and adults
• localized A-V training materials
Pennsylvania
Idaho
• catalyst to community resources
• interpretation and dissemination of health education status
• use of community library as focal point for community health education activities and planning
• interpretation and application of professional program planning to volunteer "lay" committee activities

Appendix G Activities Chart

- Conduct—
  - Awareness workshops
  - Health fairs
  - Leadership training
  - Peer parenting sessions
  - Skill-building sessions
  - International programs
  - Radio and TV interviews
  - "Parents Can Make A Difference" conference
  - Peer parent project for Head Start mothers
- Develop state and local resource directories.
- Promote school health instructional review, e. g., curriculum, teacher training, etc.
- Identify unmet community health needs.

- Consult with state superintendent of schools.
- Act as catalysts for the organization of a state task force for schools.
- Meet with university personnel about teacher training.
- Meet with the state health agency consortium to express concerns and to give support.
- Co-sponsor mental health workshops for school personnel.
- Involve school superintendents and other administrators in workshops with parents.
- Assess school health instruction including curriculum review.
- Identify special needs and assist with school health projects.

(Governmental, Voluntary, Professional and Business)

- Promote agency/school/parent cooperative projects.
- Conduct conferences with state agency directors.
- Provide schools with agency resource directory.
- Recruit agency involvement in preparation of materials.
- Encourage appropriate use of technical assistance.

- Conduct training conferences to promote positive programming.
- Review TV viewing habits in the home.
- Provide resources and consultation for programs on educational TV.

- Write letters to and consult with legislators.
- Promote awareness and concern regarding needed legislation.

Adapted from the Indiana PTA Comprehensive School Community Health Education Project (PTA leaders organized training and resources for parent-led programs at local and regional meetings). National PTA, 700 N. Rush Street, Chicago, Illinois 60611.

Appendix H Resources for School Health Information

Selected Publications from National Organizations with School Health Focus

Health Education (book), Robert D. Russell, Ed.D., 1975. Available from Order Department, OP-201, American Medical Association, Box 821, Monroe, Wisconsin 53566.

"Physician's Guide to the School Health Curriculum Process" (pamphlet) single copy free; also

"Why Health Education in Your School" (pamphlet), American Medical Association, single copy free from the Department Health Education, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610.

School Health In America: A Survey of State School Health Programs Second Edition (book), August 1979, American School Health Association, Kent, OH 44240; also

Journal of School Health (periodical).

Evaluation Instruments in Health Education, an annotated bibliography, Rev. 1979 $4.00; also

Health Education (periodical with membership) American Alliance for Health, Physical Education, Recreation and Dance, 1900 Association Drive, Reston, VA 22091.

"Education for Health in the School Community Setting," School Health and Services Section Position Paper, American Public Health Association, 1015 15th Street, N.W., Washington, D.C. 20005.

SHEP Notes; School Health Curriculum Project; Primary Grades Curriculum Project; and other resources, distributed by the National Center for Health Education, School Health Education Project, 901 Sneath Lane, Suite 215, San Bruno, CA 94066 (toll-free Number (800) 227-6934).

School Health: A Guide for Health Professionals
Latest Edition, Committee on School Health, American Academy of Pediatrics, 1801 Hinman Avenue—Box 1034, Evanston, IL 60201.

Standards for School Nurse Services, Latest Edition, $3.00, National Association of School Nurses, Inc. (affiliate of National Education Association) New York Statler Hotel—Suite 104, 7th Avenue and 33rd Street, New York, NY 10001.

Contact local or state offices of professional and voluntary associations for other school health resources.

Federal Agencies with a School Health Focus:

Bureau of Health Education
Centers for Disease Control
Department of Health and Human Services
1600 Clifton Road, N.E.
Atlanta, GA 30333

Office of Comprehensive School Health
Bureau of School Improvement
Department of Education
3700 Donahoe Building
400 Maryland Avenue, S.W.
Washington, D.C. 20202

Health Education Branch
Coordinator of School and Youth
National Heart, Lung, and Blood Institute, PHS, National Institutes of Health
Bethesda, MD 20014

Office of Health Information
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Appendix I State PTA Project Materials

Information about the 13 state PTA projects and the training materials developed to promote comprehensive school/community health education in schools and communities are available from the National PTA, 700 North Rush Street, Chicago, Illinois 60611, Attention: CS/CHEP; or from the state PTA/PTSA office in those states. Persons requesting materials may be asked to pay for postage.

**Arkansas Comprehensive School/Community Health Education Project.* Brochure—title, "Health Education." Materials that focus on the procedures for forming state and local school health advisory councils; includes criteria for selecting a demonstration school for health education curriculum, and working with a broad representation of state agency officials, including legislators. Arkansas PTA, 617 Donaghey Building, Little Rock, Arkansas 72201.

**California Health Education: Awareness and Action.* Brochure by that title. A training packet for PTA members to prepare for approaching school boards and community agencies. Includes posters, sample agendas, Health Education Issue Paper, Criteria for Evaluating School Health Education Programs, a copy of the Health Instruction Framework for California Public Schools, Kindergarten through Grade 12, and a script for a slide/cassette program, title: "California Health Education: Awareness and Action." California PTA, 930 Georgia Street, Los Angeles, California 90015.

**Colorado Health and Survival Education for School and Community.* Brochure—title "For the Health of It," other materials on local programs available. Colorado PTSA, 1005 Wadsworth Boulevard, Lakewood, Colorado 80215.

Florida: Health Education is the Basic Skill, brochure, describes areas of special concern and the Florida PTA Task Force efforts to coordinate fragmented school and community health education programs. Florida PTA, 1747 Orlando Central Parkway, Orlando, Florida 32809.

**Georgia Comprehensive School/Community Health Education.* Brochure—title, "What in Health is Going On?" Training materials and guidelines for developing a slide/cassette series outlining the problems of Georgia youth and citizens, and for compiling a directory for state and local resources. Also available: the script for a slide/cassette presentation—title, "CHE—Comprehensive Health Education." Georgia PTA, 114 Baker Street, N.E., Atlanta, Georgia 30308.

Idaho: Community Outreach for Comprehensive Health Education—A Project of the Idaho PTA, brochure, presents the work of the Pocatello Community Health Education Committee. Included are sections on PTA's concern for health education, Idaho's health education legislation, and the *Health Education Program Guides* for teachers. Idaho PTA, 620 North Sixth Street, Boise, Idaho 83702.

**Indiana Promoting Total Awareness for Comprehensive School/Community Health Education Programming.* Training materials include posters, brochures, flow charts of a structure for implementation of a statewide long-range comprehensive health program, a Check List for Evaluating a Comprehensive School Education Program. Indiana PTA, 2150 Lafayette Road, Indianapolis, Indiana 46222.

New Hampshire: Light the Way to a Better Future, brochure, relates the efforts of a Derry PTA Committee to change the snacking patterns of elementary school children and their parents, as part of their CS/CHE Project. New Hampshire PTA, CS/CHEP, 90 Lenz Street, Manchester, New Hampshire 03102.

New Mexico: Comprehensive Health Education in New Mexico Public Schools: A Community Action "Manual," 1978-80. Inspired by the materials and accomplishments of the State PTA Pilot Projects, New Mexico PTA leaders initiated the development of this guide to community action to promote comprehensive health education in New Mexico. Not a "cookbook," this manual is designed to help communities educate and organize themselves to convince their school board that comprehensive health education must be in every school. It was first published in cooperation with the New Mexico Health Association Comprehensive Health Education Task Force with a grant from the New Mexico Public Health Association. Now it is published and available from the Bureau of Health Education, CDC, DHHS, Atlanta, Georgia. New Mexico PTA, 118 Woodland Avenue, N.W., Albuquerque, New Mexico 87107.

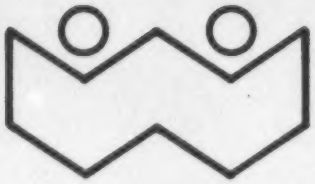
New York: Health Education is On Its Way, brochure, explains the working relationship between the New York State PTA School Health Councils and area Health Systems Agencies. This collaboration enables parents to speak out on local needs for health education, prevention and the delivery of health services. New York PTA, 11 North Pearl Street, Albany, New York 12207.

North Carolina: NC PTA Comprehensive School/Community Health Education Project fact sheet explains the work of the state task force, including a description of the project's nutrition education component. North Carolina PTA, P.O. Box 10607, 3501 Glenwood Avenue, Raleigh, North Carolina 27605.

Ohio: Comprehensive Health Education, brochure provides a summary of Ohio PTA project activities and outlines actions for PTA members' involvement in health education and promotion. A second brochure is available—*Teens Helping Teens Beating Alcohol and Drug Abuse.* PTA project-sponsored students tell of their experiences and reactions to their participation in the Teenage Institute on Alcohol and Other Drugs. It suggests student centered activities for PTA/PTSA projects on alcohol abuse prevention. Ohio PTA, 427 East Town Street, Columbus, Ohio 43215.

•*Pennsylvania: School/Community Outreach for Health Education.* A booklet describing how consumer health education guidelines developed by the Comprehensive Health Planning Association of Southwestern Pennsylvania were used by PTA leaders as a planning tool to increase public awareness about the need for comprehensive school health education. Also included are selected readings and resources for health education materials used in establishing a library based health education resource center. Pennsylvania PTA, P.O. Box 4384, 4804 Derry Street, Harrisburg, Pennsylvania 17111.

•Indicates State Pilot Projects



IV. Key Terms

CS/CHEP The Comprehensive School/Community Health Education Project initiated in 1975 by the National PTA under contract with the Bureau of Health Education, Department of Health and Human Services (formerly HEW), Atlanta, Georgia

Evaluation the process of examining and judging program effectiveness

Goal the end toward which effort is directed; in the case of the state projects, the overall goal was the establishment of a community support system to promote health education.

Health Physical, mental, social and emotional well-being. Children's health is synonymous with orderly growth and development in all of these dimensions.

Health education the process of teaching people how to become knowledgeable, independent and positively functioning human beings. Health education in the school setting should be a planned effort to help people gain sufficient control over themselves and their environments to protect and enhance their growth and development.

In-kind contribution services, facilities, time, talent, materials, et al, donated in lieu of money to achieve the project goals.

Objective a defined result of a specific activity to be achieved in a definite period of time. Objectives are stated as definite aims or goals of action; they are measurable; objectives state (1) who will experience (2) what change or benefit, (3) how much and (4) how soon.

Planning the process of establishing priorities, identifying barriers, determining a course of action, and allocating resources to achieve objectives.

Priority alternatives ranked according to effectiveness or value (importance) or both.

Program a set of planned activities designed to achieve specified objectives over a period of time.

Program Effectiveness the extent to which preestablished program objectives are attained as a result of program activity.

Project Project with a capital "P" refers to either the overall National PTA Project or any or all of the six pilot and eight demonstration states funded by the CS/CHE Project.

project Project with a lower case "p" in this manual refers to the set of activities that originate as a result of the planning process outlined in this manual.

Strategy a plan of action to employ the right forces or resources at the right time to achieve a goal or specific objectives. As used in this manual, strategies are grouped into two separate categories—gaining support for the project and managing the project.